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Post-Cairo Reproductive Health Policies and Programs in Eight Countries

This summary is based on the research report, "Post-Cairo Reproductive Health Policies and Programs: A Comparative Study of Eight Countries," by Karen Hardee, Kokila Agarwal, Nancy Luke, Ellen Wilson, Margaret Pendzich, Marguerite Farrell, and Harry Cross, September 1998. Claire Viadro prepared this brief.

Background

The International Conference on Population and Development (ICPD), held in Cairo in 1994, directed the world's attention to the need for reproductive health policies and programs. The ICPD also provided an international endorsement for addressing sensitive issues, such as reproductive rights, sexuality, and service provision for adolescents. Since 1994, many countries have worked to adopt the recommendations in the ICPD *Programme of Action*. The conference is widely believed to have contributed to a major shift in population policies and programs, deemphasizing the attainment of demographic targets and focusing on the need to improve reproductive health. Further information is needed, however, about the actual extent to which the ICPD has shaped reproductive health policies and programs at the country level. Such information can assist governments, nongovernmental organizations (NGOs), donors, and other groups to assess progress, current needs, and priorities for the future.

To this end, in 1997, the POLICY Project conducted case studies in Bangladesh, Ghana, India, Jamaica, Jordan, Nepal, Peru, and Senegal to furnish detailed descriptions of the post-Cairo policy and program environment for reproductive health.[1] Although this report reflects the situation in late 1997, all eight countries have continued to make progress in implementing reproductive health programs since that time.

Case Study Countries

- Bangladesh
- India
- Nepal
- Jordan
- Ghana
- Senegal
- Jamaica
- Peru

[1] Between July and December 1997, POLICY staff or consultants interviewed 20 to 44 key informants working in population and reproductive health in each country. Informants included service providers as well as representatives of government ministries, parliaments, universities, NGOs, women's groups, the private sector, donor agencies, and U.S. technical assistance organizations. Interview topics included reproductive health definitions, priorities, and policy formulation; support for and opposition to reproductive health; program implementation; financial resources for reproductive health; and challenges to implementing reproductive health policies and programs. Published materials and other documents were also reviewed when appropriate.

Findings

The Policy Process

Although many of the countries began shifting their policies and programs from family planning to reproductive health even before the 1994 ICPD, all eight have adopted the ICPD definition of reproductive health either in part or in its entirety.[2] Some countries have formulated reproductive health policies whereas others have produced strategic plans to link the elements of reproductive health. Specific policy accomplishments in the eight countries are summarized in the box at right.

Most countries have set some priorities among the components of reproductive health. In general, family planning remains a top priority, followed by maternal and child health and STD/HIV/AIDS prevention and treatment. Postabortion care and programs for adolescents are receiving increasing emphasis in some countries, whereas reproductive tract cancers and infertility generally have not been emphasized. In most cases, gender-based violence has not been addressed in the context of reproductive health programs. The reproductive rights aspects of the ICPD *Programme of Action* have received significantly less attention than the health aspects.

[2] The definition encompasses family planning; safe pregnancy; postabortion care; prevention and treatment of reproductive tract infections (RTIs) and sexually transmitted diseases (STDs), including HIV/AIDS; adolescent reproductive health; maternal and infant nutrition; infertility and reproductive tract cancers; and social problems such as female genital mutilation and gender-based violence.

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Summary of Policy Accomplishments

- In **Bangladesh**, policymakers have begun to work toward an integrated approach to reproductive health rather than treating individual elements of reproductive health as vertical programs.
- **India** has for the first time focused attention on client rights and choices. One of the ICPD's most significant contributions has been the elimination of contraceptive method-specific targets.
- The government in **Nepal** has drafted a reproductive health strategy; however, the country's 1997-2017 health plan does not reflect the strategy's integrated reproductive health care package.
- In **Jordan**, a task force was appointed in late 1997 to revise the country's 1996 National Population Strategy to reflect the ICPD recommendations. The revision was completed in December 1999.
- In **Ghana**, government and nongovernment representatives have developed a policy and standards document for reproductive health services as well as an adolescent reproductive health policy.
- In **Senegal**, where reproductive health is a new concept, several different plans have been developed that address aspects of reproductive health.
- **Jamaica**'s National Plan of Action on Population and Development for 1995-2015 was designed to implement the ICPD objectives and recommendations, although the plan lacks a blueprint for action.
- In **Peru**, a plan for reproductive health and family planning programs for 1996-2000 provides an overarching framework for all organizations working in reproductive health.
- Finally, **Bangladesh**, **India**, and **Senegal** have adopted an essential services package approach to providing reproductive health care.

Participation, Support, and Opposition

All eight countries have broadened participation in reproductive health policymaking. Bangladesh, Ghana, and Senegal have been relatively more effective in involving NGOs and civil society organizations in policymaking. However, some opposition remains to the adoption of policies to provide reproductive health services through an integrated approach. Sources of opposition, somewhat different in each country, include religious groups, women's groups, rural physicians, and policymakers. Some donor organizations have also been concerned with maintaining a focus on family planning.

Financial Resources

In each country, funding for reproductive health comes from a combination of government, donor, private and voluntary sector sources, and increasingly, user fees. The proportion of funding from each source differs by country. Although some respondents reported that funding levels were increasing, funding limitations are a critical obstacle in every country, except Bangladesh. All eight countries are seeking ways to improve the sustainability of their reproductive health programs.

Moving from Policies to Programs

Respondents in many of the countries stated that they were just beginning to initiate the implementation process. Most reported that the ICPD had provided the impetus to design new programs or redesign existing ones based on a client-centered, life-cycle approach that integrates reproductive health services. Respondents described policy implementation as involving various stakeholders and highlighted the need for coordination among government bodies and ministries, NGOs, civil society organizations, the private sector, and donors. At the time of the case studies, Bangladesh had made the greatest progress in setting priorities, financing, and implementing reproductive health interventions. Ghana, India, Jamaica, Nepal, Peru, and Senegal were just beginning to take steps toward implementation of reproductive health activities. Jordan has continued to focus primarily on family planning.

Policy Implications

Within their unique social, cultural, and programmatic contexts, the eight countries have made significant progress in placing reproductive health on their respective national health policy agendas. The progress illustrated by the case studies is a logical beginning for defining and adopting reproductive health policies and principles, while building political and popular support (see table). However, whereas well-established reproductive health services, such as family planning and maternal and child health, have remained high priorities, the case studies indicate that a continued effort will be required to place more sensitive issues, such

Progress toward Implementing Post-Cairo Reproductive Health (RH) Policies and Programs, 1997

Country	Adoption of ICPD Definition	Participation among Stakeholders	Support among Stakeholders	Setting Priorities among RH Elements	RH Program Implementation	Mobilization of Resources for RH
	++ adopted ICPD + toward ICPD	++ broad + partial = little	++ broad + partial = little	++ fully set + partially set = no change	++ full + partial = little/no change	++ strong + partial = little/no change
Bangladesh	++	++	++	+	+	++
India	++	+	+	+	+	=
Nepal	++	=	=	=	+	=
Jordan	+	+	+	=	=	=
Ghana	++	++	++	+	+	=
Senegal	++	++	+	=	+	+
Jamaica	++	+	++	=	+	+
Peru	+	+	+	+	=	++

as gender-based violence and reproductive rights, on the policy agenda. In addition, in some of the countries, a greater level of participation and political support for reproductive health may need to be cultivated before the countries are able to advance to the next crucial stage of implementation. Countries also need sufficient financial resources to implement the expanded reproductive health programs and services envisioned by the ICPD—resources that most respondents suggested were not immediately forthcoming.

The case studies demonstrate that countries face a variety of challenges as they move from policy formulation to program implementation. First, countries must improve the knowledge and support of reproductive health programs among stakeholders. The simple adoption of policies based on the ICPD definition has not ensured that policymakers, program managers, and health care staff understand what reproductive health means for clients and, thus, what services should be provided to clients.

Second, progress in implementing reproductive health activities has been limited in some countries by institutional constraints, the lack of planning for integrated or decentralized services, coordination problems among organizations, and disagreements over jurisdiction and responsibility. Some countries have also failed to consider the complexity of integration and the differences between administrative and service integration. An integrated reproductive health approach requires careful planning and coordination among governmental and nongovernmental agencies. In some cases, changes in institutional arrangements may be necessary.

Third, the case studies point to the need to strengthen human resources. Most of the countries face human resource challenges, such as staff shortages, lack of trained providers (particularly female providers), and overloaded workers. In addition, countries require time and resources to update curricula and service delivery guidelines to reflect an expanded reproductive health approach.

Fourth, in most of the countries, the current quality of care in family planning and other individual components of reproductive health is low. Integrating and expanding services add to the challenge of achieving a desired level of quality of care.

Fifth, the eight case studies suggest that it will be important to acknowledge and address various legal, regulatory, and cultural barriers that affect the implementation of reproductive health activities. Barriers in the eight countries vary, but include unwieldy licensing requirements for the introduction of new contraceptive methods, strict regulation of the provision of clinical contraception, resistance by the medical establishment to decentralization, and the absence of policies that govern reproductive health services for adolescents and address unsafe abortion. The study also illustrated the influence of sociocultural barriers such as pronatalism, male dominance, and the taboos surrounding discussion of topics such as AIDS, STDs, and gender-based violence.

Sixth, many respondents expressed concerns that donors seek to impose and advance their own reproductive health priorities and agendas. Although respondents' overall view of donors was generally favorable, some respondents complained of donors' overemphasis on family planning and relative neglect of other health issues. The case studies also suggest that donor coordination may need to be strengthened to reduce duplication of efforts.

Finally, the case studies point to the need to maintain a long-term perspective. Many respondents noted that three years was an insufficient period of time to assess the success of post-ICPD reproductive health policies and programs. It took more than a generation to achieve widespread adoption and implementation of family planning programs worldwide, and it may require as much time to achieve comparable progress in other aspects of reproductive health. To make progress in implementing ICPD's reproductive health goals, it will be important for countries to

- set priorities,
- prepare budgets,
- make improvements in existing services, and
- craft strategies for phasing in reproductive health interventions.